

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04109  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W Beach</i>		c. LENGTH OF STAY IN 1b <i>W Beach</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ellan</i> Middle <i>Raymond</i> Last <i>Duckor</i>		4. DATE OF DEATH Month <i>4</i> Day <i>11</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/13/58</i>
9. AGE (In years last birthday) yrs. <i>9</i>		IF UNDER 1 YEAR Months <i>9</i> Days <i>11</i> Hours <i>19</i> Min. <i>59</i>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Preschool</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Arthur Duckor</i>		14. MOTHER'S MAIDEN NAME <i>Marjorie Cadenette</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>W Beach Md</i>	
17. INFORMANT <i>Marjorie Cadenette</i>		Address <i>W Beach Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Brain Defect</i> 753.1 DUE TO <i>Diarrhea</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Diarrhea</i> DUE TO (c) <i>Diarrhea</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been a tumor and sick all 9 mos</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 mos</i> <i>9 mos</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>4/11/59</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/13/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel</i>		22d. LOCATION (City, town, or county) (State) <i>Upper Marlboro Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home, Owings</i>		ADDRESS <i>Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

9VVVVVVVVVV



4120

CERTIFICATE OF DEATH

04110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>				c. LENGTH OF STAY IN TB <i>16 hrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Beach</i>			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HARRIET</i> Middle Last <i>Holmes</i>				4. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/23/94</i>	
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Harry Gardner</i>				14. MOTHER'S MAIDEN NAME <i>June Padgett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>George Holmes - son</i> Address <i>North Beach, md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2 Mar</i> 19 <i>58</i> , to <i>18 April</i> 19 <i>59</i> , that I last saw the deceased alive on <i>18 April</i> 19 <i>59</i> , and that death occurred at <i>3:45 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>George Weems</i> M.D.							
PHYSICIAN'S NAME (Type) <i>George Weems, M.D.</i> <i>Huntingtown, md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>4-21-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Southland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Lee &amp; Sons</i>				ADDRESS <i>300 4th St N.E.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 21 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1380

1380

Reg. No. 1380

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF CLERK</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF CLERK</p>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4121

## CERTIFICATE OF DEATH

04111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>X</u> Port Republic	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Howe</u> Last <u>Howe</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min. <u>48</u>	IF UNDER 24 HRS. Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min. <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Howe</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Howe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Ellen Howe, Port Republic, Md.</u>	
17. INFORMANT <u>Ellen Howe, Port Republic, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of Prostate</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/11</u> 19 <u>58</u> , to <u>4/2</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4/2</u> 19 <u>59</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Stephen R. Devillard</u> M.D.		DATE SIGNED <u>4/2/59</u>	
PHYSICIAN'S NAME (Type) <u>Stephen R. Devillard</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>4-5, 59</u>		22b. DATE THEREOF <u>4-5, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Browns</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Frederick</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	



CERTIFICATE OF DEATH

1913

PLACE OF BIRTH		MARRIAGE	
DATE OF BIRTH		DATE OF MARRIAGE	
AGE AT DEATH		AGE AT MARRIAGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
DATE OF INTERMENT		DATE OF INTERMENT	
PLACE OF INTERMENT		PLACE OF INTERMENT	
NAME OF INTERMENT		NAME OF INTERMENT	
DATE OF BURIAL		DATE OF BURIAL	
PLACE OF BURIAL		PLACE OF BURIAL	
NAME OF BURIAL		NAME OF BURIAL	
DATE OF CREMATION		DATE OF CREMATION	
PLACE OF CREMATION		PLACE OF CREMATION	
NAME OF CREMATION		NAME OF CREMATION	
DATE OF EXHUMATION		DATE OF EXHUMATION	
PLACE OF EXHUMATION		PLACE OF EXHUMATION	
NAME OF EXHUMATION		NAME OF EXHUMATION	
DATE OF REINTERMENT		DATE OF REINTERMENT	
PLACE OF REINTERMENT		PLACE OF REINTERMENT	
NAME OF REINTERMENT		NAME OF REINTERMENT	
DATE OF RECREMATION		DATE OF RECREMATION	
PLACE OF RECREMATION		PLACE OF RECREMATION	
NAME OF RECREMATION		NAME OF RECREMATION	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04112

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>CALVERT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>CALVERT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCE FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X LUSBY.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CALVERT CO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPHUS</b> First Middle Last	4. DATE OF DEATH <b>JOHNSON</b> Month <b>4</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/27</b>
9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>MO.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>DANIEL JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>INEZ GAUGH.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>220-148102</b>	
17. INFORMANT <b>INEZ G. Johnson, husband.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION OF VOMITUS during 825X</b> DUE TO <b>ANAESTHESIA (ETHER) FOR REPAIR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>OF LACERATIONS OF BOTH KNEES</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>AUTOMOBILE ACCIDENT - WAS Passenger</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7</b> p. m. <b>4/11</b> 19 <b>59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) (County) (State) <b>CALVERT MO</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-15-59</b>		22b. DATE THEREOF <b>4-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Lusby, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. F. Sewell, Prince Frederick,</b>		24a. REC'D BY REGISTRAR <b>APR 17 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hand</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

DEPT. OF HEALTH  
BOSTON, MASS.

RECEIVED  
JAN 10 1918

RECEIVED  
JAN 10 1918

RECEIVED  
JAN 10 1918

MASS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
BOSTON, MASS.

0113

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Examiner

Signature of Physician

Signature of Coroner

Signature of Juror

Signature of Witness

Signature of Clerk

Signature of Registrar

Signature of Health Officer

Signature of Mayor

Signature of Councilman

Signature of Alderman

Signature of Justice

Signature of Sheriff

Signature of Constable

Signature of Watchman

Signature of Night Watchman

Signature of Fireman

Signature of Policeman

Signature of Prisoner

Signature of Soldier

Signature of Sailor

Signature of Merchant

Signature of Farmer

Signature of Laborer

Signature of Craftsman

Signature of Artist

Signature of Musician

Signature of Actor

Signature of Writer

Signature of Inventor



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Bessie E Pardoe</i>				4. DATE OF DEATH Month <i>4</i> Day <i>1</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1881</i>		9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months <i>7</i> Days <i>10</i>	IF UNDER 24 HRS. Hours <i>1</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Wm. H. Handersy</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>100-100000</i>		17. INFORMANT <i>Earl Pardoe Lusby Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 903.0 DUE TO (b) <i>Fall 5 hrs before</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>3 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had had a catarrh removed 6 wks ago</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell coming from bathroom at 6 AM</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>6</i> p. m. <i>4/1/59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Lusby</i> (County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>H W Ward</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>H. W. Ward</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 4, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Methodist Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Lusby Calvert Co - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. G. Harkness &amp; Son</i>				ADDRESS <i>Mt. Airy Md</i>		24a. REC'D BY REGISTRAR DATE <i>APR 6 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanks</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04114

4124

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Tyler</u> Last <u></u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Chase</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mackall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph Tyler, Prince Frederick, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Murder</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Roberta Muller</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>55</u> to <u>April 26</u> 19 <u>59</u> that I last saw the deceased alive on <u>April 26</u> 19 <u>59</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Roberto de Villarreal</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Leonard, Md.</u> DATE SIGNED <u>Arthur S. Hume</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Roberto de Villarreal</u>		<u>St. Leonard, Md.</u>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>4, 30-59</u>		22b. DATE THEREOF <u>4, 30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Youngs</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u>		ADDRESS <u>Prince Frederick</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. PLACE OF BIRTH	
5. OCCUPATION		6. MARITAL STATUS		7. COLOR		8. RELIGION	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT		16. POST-MORTEM EXAMINATION	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN WHO ATTENDS THE DECEASED, OR BY THE REGISTRAR OF DEATHS, OR BY A MEMBER OF THE CLERGY, OR BY A MEMBER OF THE FAMILY OF THE DECEASED, OR BY ANY OTHER PERSON WHO HAS KNOWLEDGE OF THE FACTS OF THE DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL TRANSMIT A COPY OF THE SAME TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

4125

# CERTIFICATE OF DEATH

04115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lusby, Md.</u>	
		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jamee</u> Last <u>Watts</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Watts</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Duane Gross, Lusby, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>59</u> , to <u>4/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>R. De Villarreal</u> M.D.		<u>S. Sherman</u>	
PHYSICIAN'S NAME (Type) <u>R. DE VILLARREAL</u>		<u>4/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-14, 59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

**○ HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**○ FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



